

‘Doing the writing’ and ‘working in parallel’: how ‘distal nursing’ affects delegation and supervision in the emerging role of the newly qualified nurse

Developed from a ‘core’ paper presented at the Nurse Education Tomorrow Conference, Cambridge University, UK, Sept 3rd to 5th 2013

A version of the paper now published by Elsevier *Nurse Education Today*
<http://dx.doi.org/10.1016/j.nedt.2014.11.020>

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Key words:

Aark Project
Delegation
Health care support workers
Multi-disciplinary working
Newly qualified nurses
Record keeping
Supervision

Wordage: 5137

Acknowledgement

Thanks to the practice education facilitators, preceptors and mentors enabling access and to the newly qualified nurses, health care support workers, nurse managers and hospital patients for their patience and support. We are grateful to the General Nursing Council Trust for their financial support.

Abstract

Background

21st Century health services are evolving at a rapid rate under pressure of multiple re-organisations, external competition, an ageing society and economic constraints. Among strategies to meet these challenges is a new skill mix which involves many more unregistered 'support' workers to compensate for the diminished role for student nurses in the workforce as a result of the move into higher education. This is happening at a time when public scrutiny of health service standards and outcomes is at an all time high.

Literature

Few published studies have investigated the evolving role of the newly qualified nurse in managing care provided by others such as health care support workers. Delegation and supervision in particular have not been widely studied. The aim of this research was to investigate the extent to which knowledge learned in the classroom was re-contextualised in the practice setting by newly qualified staff nurses. In this paper we query whether the greater awareness of accountability and surveillance culture have in many cases left the acute hospital staff nurse with a role often 'distal' to fundamental nursing care.

Methods and Analysis

We worked in three acute hospitals, two in suburban areas of the South of England and one in a large Northern city and undertook 66 participant observation periods (usually two periods each of 3-5 hours) of role performance by first year qualified nurses (N = 33). Most (28) were subsequently interviewed, and these data were supplemented with interviews with ward managers (N = 12) and health care support workers (N = 10). We took a pluralistic approach to analysis drawing inferences and themes from datasets compared and contrasted in analytic workshops.

Findings

The study as a whole elicited many themes, but in this paper we report the way in which nurses and health care support workers 'worked together' and 'worked in parallel'. That is, they worked more often than not with their peer grades of staff. A particular feature of the staff nurse role was dedication to 'doing the writing', often on a computer. Each of these ways of working is a potential limitation to the quality and amount of delegation and supervision which may be necessary to maintain high standards of care.

Conclusions

We hypothesise that classroom higher education in the skills of delegation and supervision are particularly difficult to re-contextualise in the practice setting and that the most powerful model driving such learning is modelling. This of course has the limitation that both good and less good practice may be modelled. We ask whether there might be a psycho-analytic reason for the further bureaucratisation and splitting of the nurse patient relationship (distal nursing) than is commonly acknowledged.

Background

In the context of rapid evolution of health services and care pathways in hospitals, few published studies have investigated the evolving role of the newly qualified nurse in managing care provided by others such as health care support workers (synonyms: nursing assistants; nursing auxiliaries; health care assistants; nurses' aides). In the UK nursing is organised under the control of qualified nurses who, increasingly have achieved a diploma and now graduate preparation. These are licensed (registered) by the Nursing and Midwifery Council (NMC 2013) and are responsible for the supervision of and delegation to a range of unregistered workers. These latter, however, sometimes have certificate level vocational qualifications in health and social care.

The Mid Staffs Inquiry (Francis 2013) raised concerns regarding the educational preparation of nurses. In particular it was noted that on registration nurses need to be prepared to lead compassionate care and ensure ethical standards. This paper discusses a hitherto unexplored area of nurse education and practice; namely that of newly qualified nurses (NQNs) and their ability to manage care, and if appropriate, delegate care to health care support workers. We suggest that NQNs' ability to delegate has not been well researched. We argue that there are few published studies that have investigated how newly qualified nurses and health care support workers work together and how NQNs delegate tasks to support workers and even fewer which explore how nurses generally supervise their delegated work. Since 2013 and in many areas before this the education of nurses in the UK is wholly located within higher education which has had consequences for the workforce. Before this transition care was mainly delivered by qualified nurses and their students, with assistants and orderlies being only a small fraction of the workforce in most acute settings. In this paper we show that newly qualified nurses are driven by many other priorities than the close supervision of, and team working with, health care support workers. We conclude by discussing the key concerns and questions raised by the study.

Literature

Delegation and accountability

It is clear internationally that nurses are increasingly delegating tasks to unregistered health care staff. There are many reasons, among which are rising healthcare costs, the need to maximise resources and render skill-mix more cost-effective, and due to

the role expansion of registered nurses (RNs) (Sikma and Young 2001; Standing & Anthony 2006; Weydt, 2010; Gillen & Graffin, 2010). There appears to be a greater interest in delegation in the US which may be because American culture currently has a stronger focus on accountability, legal authority and litigation (Sikma and Young, 2001; Standing and Anthony, 2008). In the US, each state has its own legal definition of delegation. In the UK, there is no legal definition of delegation (Cipriano, 2010). However the United Kingdom Nursing and Midwifery Council's Code of Conduct (2010) states that nurses and midwives must establish that anyone being delegated to is able to carry out instructions, to confirm that outcomes of tasks meet the required standards and to make sure that the delegatee is supervised and supported (NMC, 2010).

Delegation is "the process for a nurse to direct another person to perform nursing tasks and activities" (ANA and NCSBN, 2005, p1). The term is closely related to other concepts, such as responsibility, accountability and authority (Weydt, 2010). Cipriano (2010) claims that delegation is an underdeveloped skill among nurses which is difficult to assess as it relies on personality, communication style and mutual respect between the RN and the care assistant. Weydt (2010) has highlighted that delegation skills are not evaluated in the same way as other clinical skills and sees this as problematic because of its strong influence on clinical and financial outcomes. It is suggested that nurses urgently need to improve their delegation skills (Curtis & Nicholl, 2004), and it has been noted that "one of the most complex nursing skills is that of delegation. It requires sophisticated clinical judgement and final accountability for patient care" (Weydt, 2010). Therefore improvement may require training and building confidence at different stages as the newly qualified nurse matures. The consequences of poor or unsafe delegation are serious as it can lead to poor patient outcomes and concern for patient safety (Standing & Anthony 2006). They emphasise that delegation, safety and the quality of care are inextricably linked where poor delegation is "fertile ground for error". Although delegation was not explicitly highlighted in the Mid Staffs Report (Francis 2013) it is considered as part of leadership and nursing leadership was seen by the Inquiry as flawed.

Studies of nurse delegation

Research in the area of delegation has tended to be small scale and focused largely on the attitudes and experiences of the RNs. For example, Sikma and Young (2001) used interviews, public forum discussions and document reviews with nurses and nursing assistants to find out what is was like to be involved in

nurse delegation. The findings showed that RNs enjoyed the freedom of delegating as it allowed them to use professional judgement to develop new models of care; in essence to define their own practice and boundaries. It is important to realise however that professional judgement itself has to be learned, often from hard experience and with little or no time, space or support. However, their respondents acknowledged that there were risks, such as the liability for care performed by others and a lack of resources for training and supervision. Standing and Anthony (2006) interviewed acute care nurses in the US to examine the nature and significance of delegation. Their findings suggested that many nurses conceptualised delegation as the tasks that go on outside of the ward routine, and a positive working relationship was seen as key to successful delegation. Poor delegation was illustrated when assistants had not reported abnormal vital signs, not performed tasks at appointed times and talked in an inappropriate manner with patients.

In summary, research based knowledge of the practices of delegation has emerged slowly in the past decades. However, the issue of inadequate and unsafe delegation in clinical practice is still poorly understood as are the processes of supervision of support workers. This is further hampered by the paucity of work that specifically examines supervision after delegation yet it is fundamental to the transfer of responsibility (NMC 2010).

Theoretical Framework

This is a complex area in which many theories may explain social processes and behaviour. In particular we have drawn on the framework of 're-contextualisation of nursing knowledge' (Evans et al. 2010). This approach provides for thinking about programme design as re-contextualisation of curricular content and of workplace or placement support. Pedagogic re-contextualisation focuses on the approach to learning and teaching, and 'learner re-contextualisation' examines 'what the learner (in this case the newly qualified nurse) makes of it all'. In this paper we go on briefly to discuss both structural and psychoanalytic explanations for the current situation. For example, modelling clearly plays a strong part to play in the adoption of both appropriate and less desirable behaviours. Early attention brought to this by Bandura and McDonald (1963) in the case of children underlies much of the mentorship and professional socialisation literature. In a seminal paper Malone (2003) has emphasised the degree to which nurses and their role models are becoming 'distal' to patient care, explanations for which are both organisational and psychological (Menzies 1960).

Aim

To investigate the effects of academic award on newly qualified nurses' ability to re-contextualise knowledge in practice (While et al 1998; Evans et al 2010). Our primary interests were role, communications, supervision of support and other staff, delegation and the use of skills and knowledge. The aspect of the study we report here focuses on the ways in which NQNs worked with others, notably health care support workers.

Methods

From October 2011 to June 2012, and following appropriate National Health Service and Local University ethics approvals, we undertook sixty-six participant observation periods (usually two for each respondent and each of 3-5 hours) of role performance by first year qualified nurses (N = 33). We worked in three acute hospitals, two in the suburban South of England and one in a large Northern English city. We explained the nature of the project to groups on their preceptorship programmes and met with both senior ward and unit managers to clarify our purposes and remit. After obtaining written consent to both observation and interview we later 'shadowed' NQNs in a variety of daytime and night time shifts and in a wide range of wards. A similar model of observation was used in seminal work by the late Sue Pembrey (1980) who was studying the management styles of ward sisters. After orientation meetings where our agendas were agreed, data were collected by four experienced nurse researchers and two professional sociologists. Comprehensive guidance was given to observers and discussed in meetings. A particular focus of observations was how newly qualified nurses work with HCAs when delegating, supervising and organising intimate bedside care including observations (temperature, pulse, respiratory rate and blood pressure). We noted especially the importance of handovers when ward managers delegate work for the shift to staff and students. These occurred at beginning of shift – in 12 hour shift pattern, early morning (7-8am) and in three shift pattern (early, late, night), between 7-8am; around lunchtime and between 9-10pm. Drug rounds and 'nursing rounds' were also key opportunities for interactions between all levels of staff and patients.

Generally the mechanism involved joining the shift at its start and one of us working with (shadowing) the agreed nurse and her or his closest co-workers, such

as students or health care support workers and making field notes as appropriate. It was often possible to 'observe' the key features of nursing work in which we were interested from a discrete distance, such as the table by the window in a six bedded ward. This often meant going with the nurse to the 'clinical' room where medications might be dispensed, sitting by the 'night station' or ward table where computers were being accessed to retrieve or input data, or to attend a side ward where care was being carried out or managed. Where it seemed appropriate and helpful we chatted to patients and others to explain our purposes.

Nearly all NQNs were observed on at least two occasions and were followed up with interviews exploring their perceptions of role and context. Similar interviews were extended to ward managers (N = 12) and support workers (N = 10) as a form of triangulation (Johnson et al. 2001). The digitally recorded interviews usually took place by appointment in side wards or ward offices at quiet times of the day or shortly after shifts and were transcribed by a professional research administrator. The interviews had general themes as follows:

Table 1 here please

Ethical Issues

We established ground rules, made clear in the consenting procedure, that conduct or standards giving rise to concern would need to be disclosed to appropriate authorities. Indeed in this context, we were a little concerned that the weight of surveillance already on NQNs and their colleagues might be such that they would be reluctant to be observed, or might feel coerced. We were surprised to find that reluctance to take part was rare and we feel it helped that some research team members were known to some of the NQNs through contributions to their initial nursing education as lecturers. Although some content of interviews describes unsafe conduct, thankfully it had been detected and dealt with at the time, indeed even a nurse who had been in this situation was happy to be observed, having learned from the experience. Because of the busyness of the setting, the many people coming in and out and the possibility of some of those present being too ill, it is possible that not everyone was fully aware of our precise role. We were in no sense 'deliberately covert', however (Johnson 1992). All data were kept according to the Data Protection Act and Caldicott principles and anonymity has been guaranteed to individuals (Department of Health 1997).

Data analysis

We are aware of the many styles and strategies which can be applied to qualitative data to derive meaning, to theorise and to draw conclusions. Since claims to 'purity' in these respects are commonly spurious, rather than suggest any specific allegiances, but having worked extensively with grounded theory, phenomenological and ethnographic approaches we shared our data and worked in teams of two or three to code and re-code it, sharing our interpretations in several face to face meetings reconciling main findings in debate. We could say our approach is qualitative and pluralistic (Johnson et al. 2001).

Findings

The NQNs hope to build on 'university' knowledge including delegation, supervising the work of support workers, 'handing over' and communicating through various meetings such as 'huddles'. The use of complex and detailed computer software which was in use in some settings (in this case Isoft TM) is not taught in the Universities but learned on qualification. In this paper we focus on themes arising from interview and observation data from fieldwork with NQNs, health care support workers and managers (Figure 1). We draw on particular themes of 'working together', 'working in parallel' and 'doing the writing', to suggest how the role of the staff nurse has evolved bureaucratically with both negative and positive outcomes.

Figure 1 about here

'Working together': delegating but being accountable

As has been found elsewhere in studies of nurses' transition to qualified status, their awareness of accountability for care they both give themselves and that they delegate and supervise has never been more profound (Lauder et al. 2008). New forms of education, target driven health care and an ever more aware public are driving up both managerial and professional surveillance to new levels. Students are well briefed, and this is reinforced on preceptorship programmes, about their personal accountability both to their own employers, in this case NHS Trusts, and to the UK regulatory body the Nursing and Midwifery Council, to which over 4000 nurses are reported annually. As a NQN pointed out:

...even though you've had three months supervised practice you know, you've had that break over the summer and then you suddenly go in there [practice] and I

mean as a student I thought I did well to manage my own patients, but in the real world you know, you're very much protected as a student and you don't manage as much as you do as a nurse so that's, so I think that my biggest thing was the accountability for me, that was the shock to me, that I'm now responsible for the care assistants getting it right.' (B/Int/Nurs2)

NQNs were often concerned that support workers can be 'clicky', that is to say get on well with senior staff and seem to have a good deal of autonomy in planning care themselves, especially when they have been around for years. Many had 'strong personalities' and one new staff nurse complained that:

"They know you're new and they will try to intimidate you, I'm not going to lie....sometimes you end up doing it yourself, but I think it's more of learning who you are working with and learning how to handle different people." (B/Int/Nurs3)

This was experienced as very dis-empowering for the NQNs, but some felt that provided they spoke to senior staff or ward managers these latter could 'turn it around', that is to say they could ensure that the support staff accepted their authority to supervise and delegate. This was all seen as a process of 'finding your feet' which all had to endure and many found very stressful. Working out which care assistants could be safely delegated to was very challenging, and some new staff had 'learned the hard way' which support staff they could trust. Previous studies have noted that whatever training and certification staff may have, qualified nurses find it wise to check competence of colleagues for themselves, especially where considerable risk is present (Johnson et al. 2004).

In one key example a busy new staff nurse allowed a health care support worker to check the identity of a theatre patient, but one of two name bands on this patient had the wrong name, which could easily have led to the patient undergoing the wrong procedure. Quite rightly, but painfully for the nurse, the doctor who discovered the error had to report it and the nurse lost a good deal of her confidence as a result of the subsequent inquiry.

Working in Parallel

In our interpretation one of the most disabling aspects of the evolution of new patterns of working in the new hospital division of labour was the practice of 'parallel working'. We commonly observed health care support workers arriving for a new shift, and with a minimum of handover or opportunity for detailed instruction by qualified staff beginning their routine. This could involve sitting patients up, washing patients or giving out bowls, turning patients and helping with meals. Equally, NQNs would receive a report about their fraction of the patients on the ward and then begin observations, medicines and 'doing their writing' (see below). Where medicines required two persons to check them, this meant two qualified nurses working together. Whilst positive as a demonstration of confidence in the support staff and a seemingly appropriate use of qualified nurses' expertise, this effectively meant that the two grades of staff rarely worked together, except occasionally to manage challenging patients, or those requiring two staff by protocol ('doubles'). This 'working in parallel' was a prominent feature of ward work in many of our observation periods, and is clearly a threat to the NQNs' ability to relate closely to patients through performance of fundamental (basic) care.

A Senior Health Care Assistant (Band 3) at Hospital C gave us a detailed account of the morning activity which we had observed and in which, after a handover at 07.30hrs, she first gave out breakfasts feeding anyone who needed it, and then began washing those patients who needed assistance and helping some patients to the bathroom to care for their own hygiene needs. Where necessary she would be helped by another care assistant, and then they would make beds until about 11am when they would begin observations and dressings:

"I usually do the dressings and all that, but if it needs sterile technique the qualified nurses do that...(for example) if it is deeper and has to be packed with special ribbon, then we can remove (it) and get them ready for the qualified nurse."
(C/Int/HCA1)

Although there is clearly blurring of the supposed division of labour in which observations and dressings might be seen as 'qualified' nurse work, there is no doubt that for the most part 'nursing' and 'health care support worker' grades work separately for much of the time, which can be conveniently called 'working in parallel'. In a field-note we recorded shadowing a newly qualified nurse at Hospital A as she was explaining how the work would go that day:

“A good day today....we are well staffed, because we have two Health Care Assistants we told them to go around and do washes together, it helps us loads, but other days you don’t know if you are coming or going.” (A/Obs/Nrs16)

This mode of working seems to allow the expedient delivery of instrumental care when the support worker, as in this case, is very experienced. It minimises, however, the opportunity for direct supervision of the standard and competence of the worker by a registered nurse except in an ad hoc fashion. Indeed, the autonomy of support workers (in this case HCAs) to work relatively unsupervised could occasionally cause problems. The Ward Manager of a different unit in Hospital C...gave the following example:

“We had one health care support worker and we did have some issues with her, and one morning she’d left a very sick patient till the end of her work, instead of prioritising her, left her actually sitting in melaena¹ for the morning.” (C/Int/WM/2)

Given the demonstrably delicate adjustments some of the NQNs are making in trying to grasp authority both to delegate to and to supervise such experienced ancillary workers, supervision and delegation are very challenging aspects of the new staff nurse’s role. That said some NQNs we observed seemed to have excellent skills in assertive negotiation of appropriate work from both subordinates and other more senior staff such as doctors.

“Doing my writing”

Perhaps the most profound limits to the ability to supervise and delegate appropriately came from the pressures NQNs felt to keep pace with the routine, but important and time-consuming role activities such as administering medicines, taking observations, and especially maintaining up to date records. Here, however, we focus on the increasing commitment to record keeping.

Many interviewees referred to ‘doing my writing’ as a key task to be completed frequently during a shift, and often for large parts of it. At Hospital A one nurse articulated a link between the pressure to complete her reports and the need to delegate:

¹ Faeces and blood indicative of serious gastro-intestinal bleeding

Yes, I think it's hard when you're writing (and) you're saying (to the HCA) 'can you do this?' but it looks like you're sat down... you're doing something that needs to be done, but I was a support worker and so I know what it's like when you see people sat there and you think you know." (A/Int/Nrs/1)

This nurse is suggesting that some support workers regard record keeping as a avoidance of 'real work' as it involves sitting at a desk. Intriguingly whilst shadowing this thoughtful and diligent nurse we noted that she found a pool of dark brown faecal smelling fluid on the floor in a gentleman's sideward. Initially she indicated that she would be asking a domestic or health care support worker to clear this up, but a few minutes later she was doing it herself. This could be seen as a failure to delegate, but the situation is much more complex than this. Rather, this was better interpreted as a caring act, one which showed the very ill man in the room that the mess was unimportant and nothing to be made a fuss of. Rather than poor delegation it was perhaps compassionate nursing at its best (Curtis et al. 2012).

The process varied somewhat according to the unit or hospital, for example not all were fully computerised in this respect, but the emphasis remained. In one of the large acute hospitals studied staff collected A4 printed sheets at the start of a shift, each of which had all the names and main conditions of patients in the ward/unit. These were used as a basic record of tasks and activities to be undertaken during the day as various change of shift handovers took place.

In this hospital the care plans and progress notes were entered into proprietary Isoft™ computer programmes together with information on various 'Care Pathways' that were being used (MRSA, C. Difficile, Care of the Dying, Dignity, 'Behavioural', 'Pressure Ulcer' etc). Incident reports have become a key feature, with falls and untoward incidents much more likely to be recorded in detail than in the past (Wakefield et al, 2005). In this hospital, as in others, and as a result of much publicity attached to them by the UK Prime Minister David Cameron, a good deal of effort was sometimes put into 'hourly roundings', or attempts to interact with all patients on an hourly basis to check comfort levels, freedom from pain, need for elimination and any other obvious daily living needs. At other times and in some wards, these 'roundings' were seen as rather excessive where patients seemed to be largely self-caring. We certainly saw that often they were, against protocol,

completed retrospectively. Among other important 'electronic paperwork' were preparation for discharge, pharmacy, clinical records, social needs and arrangements and requests for transport both within and outside the hospital.

It became clear in interviews that little or no training existed in the local pre-registration programme in the use of the software and much of the 'paperwork'. In this hospital, tablet and 'mobile' computers (on trolleys) which were meant to increase ease of access in clinical areas were sometimes not reliable, adding to frustration and the need to work in the office rather than within sight of patients and/or health care support workers whose work was meant to be being supervised. Commonly nurses could not use their own 'log in' and the overall system would fail from time to time. When hardware worked well, nurses felt this helped because they could 'write on the move', but this reinforces the notion of its super-ordinate importance in their priorities. Contrary to feeling the NQNs were 'taking it easy', other health care support workers, often pleased to express their love of their role in working directly with patients, noted that they 'felt sorry for the nurses', the 'writing' being such a chore. NQNs regularly told of how much better they felt when their 'writing' was done. In a field-note we recorded an informal chat with the Ward sister on an orthopaedic ward:

"There's too much paperwork. It seems like there are new forms every day. Most of it's on-line, which is good in some ways when you get used to it, but it reduces one to one care a lot. I'm going to work on the community because I want one to one care again, I like sitting with the patients and talking to them." (A/Obs/Nrs12)

This view was echoed by a health care support worker who is explaining how she tries to help the nurses with their work:

"Yes...after some time we can help them more, I think they are really very busy because they have to do paperwork and they have computer work too and they have to do technical work too..." (A/Int/HCA/6)

It is clear that 'doing the writing' has evolved as a major part of the staff nurse role in recent years, and that the amount and detail involved greatly exceeds that when Pembrey and others were studying the supervision and delegation of ward work by ward sisters in the 1980s.

Limitations

This paper is drawn from a large qualitative study of nurses and their co-workers at three diverse hospitals in the South and North of England and reports just a focused aspect of our findings. Respondents volunteered, but very few of those in the relevant population declined to take part if asked, so we have some confidence that our informants are credibly typical of people in similar roles elsewhere. Observation is necessarily selective, but we feel that our strategy of having six different but well briefed observers added perspective to the fieldwork without overcomplicating it. Certainly 'shadowing' nurses allowed us to get critical insights both then and in subsequent interviews which we feel were very meaningful.

Discussion

The expansion in the commitment to and accountability for written records of nursing and related activity, together with the substantial separation in the daily work routine between nurses and health care support workers has conspired to make delegation and supervision of subordinate workers who actually provide much personal physical and emotional care very difficult and in some cases impossible. This situation has been compounded by the greater need to focus on technical tasks such as detailed monitoring of physiological and clinical parameters, more complex medications and much more rapid throughput in most units.

In the context of both greater numbers of support workers in the workforce and the fact that they are now eligible for membership of the Royal College of Nursing that body has produced basic guidance to nurses and support workers about their respective responsibilities in respect of delegation and supervision of work (Royal College of Nursing 2011). They summarise the document as follows:

- All patients should expect the same standard of care, whoever delivers it. When delegating any aspect of care, it must be determined that delegation is in the best interest of the patient.
- The person who delegates the task is accountable for the appropriateness of the delegation.
- If the delegation of a task to another person is appropriate, the support worker is accountable for the standard of performance.
- The level of supervision provided must be appropriate to the situation and take into account the complexity of the task, the competence of the support worker, the needs of the patient and the setting in which the care is being given.

To some extent the document admits of the complexity of delegation and supervision and who precisely is accountable for actions. It also reminds the reader that the employer remains vicariously liable for actions in these circumstances, particularly where skill mix is inappropriate. A layer of difficulty is added to decisions to delegate and how much to supervise with 'bank' staff from both NHS and private companies frequently present.

Compared, for example, to military and civil service organisations, hospitals are 'deviant' bureaucracies (Davies 1972). This relative complexity arises because several competing professional groups vie for the authority to manage clinical and bureaucratic work. Davies' early paper discussed medical consultants but makes clear that the doctors' authority to delegate came not from a clear place in the hospital hierarchy but from 'professional dominance', in which they are able to issue orders to a range of other occupations not all of which are strict subordinates. For the newly qualified nurse the authority necessary to delegate is in many cases only slowly assumed because it depends on experience, knowledge and the perceptions of 'subordinates' that the authority is legitimised by these two qualities. Drawing on work by Evans et al (2010) Allan and Smith show that even when the skills and knowledge necessary for appropriate delegation are taught in the classroom, translating this knowledge into the real clinical world is fraught with challenges (Allan and Smith 2010). Key among these is that the necessary professional judgement takes time, space and support to develop. They argue that in all likelihood the learning of skills like supervision and delegation is 'informal' and dependent more on the social relations in the clinical setting than anything that can be taught or learned in the classroom (Hager, 2000).

As we indicated earlier it is possible to speculate on a wide range of theories which might illuminate the process by which the range of skills necessary for effective delegation and supervision might be learned. In our estimation the most powerful of these is 'modelling', that is the observation and then copying of the behaviour in others, particularly when it is effective. Bandura and McDonald's early paper explaining this with children may seem distant from the case in point, but there is wide consensus that the most powerful model of learning professional behaviour takes precisely this 'apprentice' approach. Unfortunately, as a similarly extensive literature on professional socialisation shows, the behaviour modelled may not be ideal unless the role models are carefully selected and skilled in the art of including

neophytes when opportunities to demonstrate good practice arise (Allan and Smith 2010, Becker et al. 1961, Melia 1987, Psathas 1968).

Drawing on the situation in the USA Ruth Malone develops the concept of 'distal nursing' in which, she argues, nurses are increasingly driven away from proximity to patients (Malone, 2003). She suggests nurse-patient proximity is of three kinds, physical, narrative and moral. Physical includes for example the traditionally important acts of washing, taking people to the toilet, even the ceremonial but now discarded 'back rub' in which nurses came to know their patients, which latter she calls 'narrative proximity'. Out of these come 'moral proximity' in which the nurse learns to 'be there for' and arguably advocate for the patient. Giving more space to a theory of structural-spatial relations than we can here, Malone's paper elegantly argues nursing's proximity to patients is being lost along each of these dimensions concluding:

If we want educated practitioners who engage with us on a human level, as opposed to merely processing our bodies, we must consider how spatial-structural power relations further or obstruct relationships between patients and healers.

(Malone, 2003, p 2325)

In the 1960s Isobel Menzies (1960) proposed that nursing was so stressful that, building on individual psychological defence mechanisms in each nurse, 'institutional defences' had evolved to protect the psychological security of nursing staff in the face of suffering, death and suppressed sexual feelings inherent in the often intimate clinical work undertaken. Her explanation, based on the work of Melanie Klein (1959), proposed that 'splitting' of the nurse patient relationship by routinisation, social distance and task allocation were the main elements of this defence. Indeed Allan (2011) draws on this approach in small group teaching to integrate theory and practice. Despite the date of Menzies' work, and the extent to which the nurses we observed develop first name relationships with their patients, the theory probably continues partially to explain the retreat to the desktop technical tasks implied by our analysis. This of course begs the research question: 'If true, what defensive strategies are employed by those closest to the patient, such as the health care support workers and who is now responsible for 'emotional labour' (Smith, 1992)?'

Conclusions and Key Messages

We argue that evolution of role of the acute general hospital staff nurse away from bedside care is less to do with a training undertaken in higher education than the demands of new skill mixes with support workers and transient bank staff forming an important part of the workforce. The newly qualified nurses we worked with are acutely aware of the new culture of management surveillance, personal accountability and their responsibility for the work of others. This can mean that the need to maintain records often supersedes involvement in personal nursing care however altruistic the nurse. Perhaps the focus on paperwork is part of a defence entailing disengagement from direct emotional involvement with patients, but this needs further exploration.

These data derive from Phase One of a substantial GNC Trust funded study ‘Academic Award and Re-contextualising Nursing Knowledge’ (Aark). From our analysis we have derived a tool for newly qualified nurses, mentors and preceptors to work with in developing the skills of delegation, an aspect we expect to report subsequently.

Key messages:

- The modern role of the staff nurse is driven more by skill mix than patient needs
- Writing, mostly on computers, is a time consuming priority for qualified nurses in a highly accountable culture
- The curriculum prepares nurses only partially for the many demands of supervision, delegation and accountability in the emerging role
- Good ward leadership and preceptorship go some way to improving delegation and supervision but both structural and interpersonal factors need to be addressed to idealise these skills
- Research is needed into the consequences for patient safety of nursing skill mix, competence in delegation and supervision, and the most appropriate and effective methods of ensuring accountability

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Figure 1

Aspects of the Modern Role of the Staff Nurse



Table 1

Indicative NQN interview questions
1. What experience do you have of working as a registered nurse and supervising health care assistants (HCAs), organising and delegating the care of patients?
2. How do you make sure that the care HCAs provide to patients is of good quality and safe?
3. Do you ever have concerns that the care HCAs provide is not good quality and safe?
4. What skills and competencies do you as a nurse need to supervise and delegate care?
5. How and where do you learn or acquire those skills or competencies?
6. Are there any other things or factors that effect how you organise and delegate care?
Answers were followed up with subsidiary questions and appropriately modified questions were used interviews of support workers and managers